

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00585

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>5 mos. 5 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>EASTERN SHORE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Illie</u> First <u>Abbott</u> Middle <u>-</u> Last <u>Abbott</u>		4. DATE OF DEATH <u>January 15 19 60</u> Month <u>January</u> Day <u>15</u> Year <u>19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 29, 1883</u> 9. AGE (in years last birthday) <u>74 7/16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dressmaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Abbott</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Malone</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>RECORDS: EASTERN SHORE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck right femur.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell from chair in hospital</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:30 a.m. 12-28- 19 59</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>		20f. (City or town) (County) (State) <u>Cambridge Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-18-1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will + G Johnson</u>		ADDRESS <u>Salisbury, Md.</u>	
24a. REC'D BY REGISTRAR <u>Norman E. Baker</u>		DATE <u>JAN 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



WESTLAND STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		CAUSE OF DEATH		MANNER OF DEATH	
PREVIOUS ILLNESS		TREATMENT		HISTORY		FAMILY HISTORY		SOCIAL HISTORY		SUBSTANCE ABUSE	
PHYSICIAN'S SIGNATURE		DATE		TIME		LOCATION		WITNESSES		CORONER'S SIGNATURE	
MEDICAL EXAMINER'S SIGNATURE		DATE		TIME		LOCATION		WITNESSES		CORONER'S SIGNATURE	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00588

0606

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fishing Creek</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fishing Creek</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Catherine</b> Middle <b>Lampus</b> Last <b>Bassler</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1869</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>New York, N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Christian Lampus</b>		14. MOTHER'S MAIDEN NAME <b>Barbara Meyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mrs. George J. Rimm, Fishing Creek, Md.</b>	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 MOS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/18</b> , 19 <b>59</b> , to <b>1/27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/4</b> , 19 <b>60</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. E. GUNBY JR.</b> M.D.		ADDRESS (Street, city or town, state) <b>105 CHURCH ST. Cambridge Maryland</b>	
PHYSICIAN'S NAME (Type) <b>W. E. GUNBY JR.</b>		DATE SIGNED <b>1/28/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 30, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Vernon, N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emeth R. Shuman</b> ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 0607 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Finchville</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Clay</b> Last <b>Batson</b>		4. DATE OF DEATH Month <b>January</b> Day <b>5</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee of State Roads Commission</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dorchester Co., Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jeremiah Batson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Evans</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Virgie C. Batson, Rhodesdale, Md., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-28-1958</b> to <b>1-5-1960</b> , that I last saw the deceased alive on <b>1-4-1960</b> , and that death occurred at <b>7 A.</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John C. Rawlins</b>		ADDRESS (Street, city or town, state) <b>202 High St., Seaford, Del</b>	
PHYSICIAN'S NAME (Type) <b>John C. Rawlins, MD</b>		DATE SIGNED <b>1-9-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 9, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cokesbury Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. BROWN		45		M		W		1910		BOSTON	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BIRTH		PLACE OF BIRTH	
123 Main St.		Carpenter		Heart Disease		Natural		1865		Ireland	
FATHER		MOTHER		SPOUSE		CHILDREN		EDUCATION		RELIGION	
JAMES BROWN		MARY BROWN		JANE BROWN		JOHN BROWN		High School		Roman Catholic	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		POST-MORTEM		BURIAL		OTHER	
None		None		None		None		Buried		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		DATE OF REGISTRATION		PLACE OF REGISTRATION	
[Signature]		[Signature]		[Signature]		[Signature]		1910		BOSTON	

THE COMMISSIONER OF THE DEPARTMENT OF HEALTH

BOSTON

1910



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00588

0608

1. PLACE OF DEATH o. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>3 MOS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS <u>100 SYLVIA ST.</u>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>MARIE</u> Last <u>BENNETT</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>10</u> Year <u>1960</u>					
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1881</u>		9. AGE (In years lost birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND (Somerset Co)</u>		12. CITIZEN OF WHAT COUNTRY? <u>S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN HITCH</u>				14. MOTHER'S MAIDEN NAME <u>ELLA CANTWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>WILLIAM BENNETT, 100 SYLVIA ST. SALISBURY. (husband)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>STRANGULATED FEMORAL HERNIA HERNIOGRAPHY</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCT 14</u> , 19 <u>59</u> , to <u>JAN 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>JAN 8</u> , 19 <u>60</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>George H. Longley</u> M.D. <u>EASTERN SHORE STATE HOSP</u>				DATE SIGNED <u>1/10/60</u>			
PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>				<u>CAMBRIDGE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 12, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>HOLLOWAY &amp; COMPANY SALISBURY, MARYLAND</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 12 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF CEMETERY [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF CEMETERY [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF CEMETERY [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF CEMETERY [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	
NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		PLACE OF BURIAL [REDACTED]	
NAME OF PHYSICIAN [REDACTED]		NAME OF FUNERAL HOME [REDACTED]		NAME OF CEMETERY [REDACTED]	
NAME OF NEXT OF KIN [REDACTED]		NAME OF SURVIVOR [REDACTED]		NAME OF WITNESS [REDACTED]	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00583

0587

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN lb <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reids Grove - Rhodesdale, R.F.D.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John H. Cannon</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARITAL STATUS <b>WIDOWED</b>	8. DATE OF BIRTH <b>About 1876</b>		9. AGE (In years last birthday) <b>About 82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Labor (Farm)</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown Dorchester Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Elisha Cannon</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Mary (maiden name unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Records Cambridge Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>1/25/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR <b>JAN 29 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. King</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



0582

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death	
John Doe		Male		45		White		1945		Home	
Residence		Occupation		Cause of Death		Manner of Death		Time of Death		Signature of Examiner	
123 Main St.		Teacher		Heart Disease		Natural		10:00 AM		J. Smith	
City		County		Hospital		Physician		Nurse		Burial Place	
Baltimore		Anne Arundel		St. Mary's		Dr. Jones		Miss White		Cemetery	
State		Federal		Local		State		Federal		Local	
Maryland		USA		Baltimore		State		Federal		Local	
County		City		Street		Apartment		Room		Box	
Anne Arundel		Baltimore		Main		101		101		101	
State		City		Street		Apartment		Room		Box	
Maryland		Baltimore		Main		101		101		101	
County		City		Street		Apartment		Room		Box	
Anne Arundel		Baltimore		Main		101		101		101	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00590

0588

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>		d. STREET ADDRESS <b>207 Boundary Ave.,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Noble</b> Middle <b>Stewart</b> Last <b>Cannon</b>		4. DATE OF DEATH Month <b>January</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 28, 1894</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cambridge</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William S. Cannon</b>		14. MOTHER'S MAIDEN NAME <b>Lula Condon Cannon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes World War 1</b>		16. SOCIAL SECURITY NO. <b>218-34-2915</b>	
17. INFORMANT <b>Mrs. Robert L. Dail, Glasgow St., Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>-- --</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obstructive tumor colon splenic flexure</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 mins.</b> <b>unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-- -- --</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>--</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-- --</b>		20f. (City or town) (County) (State) <b>-- --</b>	
21. I certify that I attended the deceased from <b>12-10-59</b> , 19 <b>59</b> to <b>1-9-60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-9-60</b> , 19 <b>60</b> , and that death occurred at <b>5:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>15 Locust Street, Cambridge, Md.</b> DATE SIGNED <b>1-10-60</b>			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		M.D. <b>15 Locust Street, Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Shuman</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	



## 0589 CERTIFICATE OF DEATH

00591

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN 1b <b>28 hrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hospital Inc.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rhodesdale</b> d. STREET ADDRESS <b>Route # 1</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dawn</b> Middle <b>Michelle</b> Last <b>Chester</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>19 60</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-60</b>
9. AGE (In years last birthday) yrs. <b>4</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>4</b> Hours <b>22</b>	IF UNDER 24 HRS. Min. <b>22</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Leon Chester Jr.</b>	
14. MOTHER'S MAIDEN NAME <b>Marie Pinkett</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Marie Chester</b> Address <b>Rhodesdale, Md. Route # 1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral anoxia</b> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>atelectasis</b> DUE TO (c) <b>---</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> 19 p. m. <b>---</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-25</b> , 19 <b>60</b> , to <b>1-26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-26</b> , 19 <b>60</b> , and that death occurred at <b>1:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		ADDRESS (Street, city or town, state) <b>Cambridge Md.</b> DATE SIGNED <b>1-26-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Eldridge H. Wolff</b>		<b>1501st St. Cambridge, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>---</b>	22b. DATE THEREOF <b>1-27-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rhodesdale A.M.E. Zion</b>	22d. LOCATION (City, town, or county) (State) <b>Rhodesdale Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leon Chester Jr.</b>		ADDRESS <b>Rhodesdale</b>	24b. REGISTRAR'S SIGNATURE <b>William L. Krawa</b>
24a. REC'D BY REGISTRAR <b>---</b>		DATE <b>FEB 1 '60</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067222XV5





CERTIFICATE OF DEATH

Reg. Dist. No.

00592

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>212 West End Ave</u>		d. STREET ADDRESS <u>212 West End Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>Kirby</u> Last <u>Clift</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>20</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 4, 1886</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Mary Weber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>Unknown</u>	
17. INFORMANT <u>Mrs Everett Creighton</u>		Address <u>Cambridge Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Phlebotrombosis, leg veins</u> DUE TO (c) <u>Recurrent adenocarcinoma of colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>?</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 11, 1959</u> , to <u>Jan 20, 1960</u> , that I last saw the deceased alive on <u>Jan 19, 1960</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lewis M. Burdett</u>		ADDRESS (Street, city or town, state) <u>1 Locust St Cambridge Md</u>	
PHYSICIAN'S NAME (Type) <u>Cambridge Md</u>		DATE SIGNED <u>1/21/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan 22, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge Maryland</u>	
24a. REC'D BY REGISTRAR <u>JAN 28 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>	
<p>6. OCCUPATION</p>		<p>7. MARITAL STATUS</p>		<p>8. EDUCATION</p>		<p>9. RELIGION</p>		<p>10. RACE</p>	
<p>11. CAUSE OF DEATH</p>		<p>12. MANNER OF DEATH</p>		<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. PLACE OF DEATH</p>	
<p>16. SIGNATURE OF DECEASED</p>		<p>17. SIGNATURE OF WITNESS</p>		<p>18. SIGNATURE OF PHYSICIAN</p>		<p>19. SIGNATURE OF CORONER</p>		<p>20. SIGNATURE OF JUDGE</p>	
<p>21. SIGNATURE OF CLERK</p>		<p>22. SIGNATURE OF REGISTRAR</p>		<p>23. SIGNATURE OF NOTARY</p>		<p>24. SIGNATURE OF SHERIFF</p>		<p>25. SIGNATURE OF DEPUTY SHERIFF</p>	

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00593

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester</u> <span style="float: right;">0591</span> MARYLAND			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Md. Hospital</u>			d. STREET ADDRESS <u>1 Moores Ave. Ext.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Roosevelt</u> Middle <u>Coleman</u> Last <u></u>			<b>4. DATE OF DEATH</b> Month <u>Jan.</u> Day <u>9</u> Year <u>19 60</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July, 26, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Coleman</u>			14. MOTHER'S MAIDEN NAME <u>Rheta Wheatley</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>217-10-8450</u>	17. INFORMANT Address <u>Pearl Coleman Moores Ave. Cambridge, Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage and shock</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun shot wound neck.</u> DUE TO (c) <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs. 45 min.</u>  <u>2 hrs. 45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Was shot with 16g. shotgun by Charles Bryan.</u>			
20c. TIME OF INJURY Month, Day, Year <u>9:45</u> a. m. <u>1/9/</u> 19 <u>60</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>John Mace Jr.</u> M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/12/60</u>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Dor. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>StClair</u>			ADDRESS <u>Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '60</u>
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			DATE		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Registrar of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00341

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. POST-MORTEM EXAMINATION	
16. SIGNATURE OF EXAMINER		17. SIGNATURE OF WITNESS		18. SIGNATURE OF CORONER		19. SIGNATURE OF JURY		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF CLERK		22. SIGNATURE OF NURSE		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DENTIST		25. SIGNATURE OF OTHER	
26. SIGNATURE OF CHURCH		27. SIGNATURE OF FUNERAL HOME		28. SIGNATURE OF BURIAL		29. SIGNATURE OF CREMATION		30. SIGNATURE OF OTHER	
31. SIGNATURE OF STATE		32. SIGNATURE OF COUNTY		33. SIGNATURE OF CITY		34. SIGNATURE OF TOWNSHIP		35. SIGNATURE OF VILLAGE	
36. SIGNATURE OF WARD		37. SIGNATURE OF PARISH		38. SIGNATURE OF DISTRICT		39. SIGNATURE OF PRESTBYTERY		40. SIGNATURE OF OTHER	
41. SIGNATURE OF DEPARTMENT		42. SIGNATURE OF DIVISION		43. SIGNATURE OF SECTION		44. SIGNATURE OF BRANCH		45. SIGNATURE OF OFFICE	
46. SIGNATURE OF BUREAU		47. SIGNATURE OF DIVISION		48. SIGNATURE OF SECTION		49. SIGNATURE OF BRANCH		50. SIGNATURE OF OFFICE	
51. SIGNATURE OF BUREAU		52. SIGNATURE OF DIVISION		53. SIGNATURE OF SECTION		54. SIGNATURE OF BRANCH		55. SIGNATURE OF OFFICE	
56. SIGNATURE OF BUREAU		57. SIGNATURE OF DIVISION		58. SIGNATURE OF SECTION		59. SIGNATURE OF BRANCH		60. SIGNATURE OF OFFICE	
61. SIGNATURE OF BUREAU		62. SIGNATURE OF DIVISION		63. SIGNATURE OF SECTION		64. SIGNATURE OF BRANCH		65. SIGNATURE OF OFFICE	
66. SIGNATURE OF BUREAU		67. SIGNATURE OF DIVISION		68. SIGNATURE OF SECTION		69. SIGNATURE OF BRANCH		70. SIGNATURE OF OFFICE	
67. SIGNATURE OF BUREAU		68. SIGNATURE OF DIVISION		69. SIGNATURE OF SECTION		70. SIGNATURE OF BRANCH		71. SIGNATURE OF OFFICE	
68. SIGNATURE OF BUREAU		69. SIGNATURE OF DIVISION		70. SIGNATURE OF SECTION		71. SIGNATURE OF BRANCH		72. SIGNATURE OF OFFICE	
69. SIGNATURE OF BUREAU		70. SIGNATURE OF DIVISION		71. SIGNATURE OF SECTION		72. SIGNATURE OF BRANCH		73. SIGNATURE OF OFFICE	
70. SIGNATURE OF BUREAU		71. SIGNATURE OF DIVISION		72. SIGNATURE OF SECTION		73. SIGNATURE OF BRANCH		74. SIGNATURE OF OFFICE	
71. SIGNATURE OF BUREAU		72. SIGNATURE OF DIVISION		73. SIGNATURE OF SECTION		74. SIGNATURE OF BRANCH		75. SIGNATURE OF OFFICE	
72. SIGNATURE OF BUREAU		73. SIGNATURE OF DIVISION		74. SIGNATURE OF SECTION		75. SIGNATURE OF BRANCH		76. SIGNATURE OF OFFICE	
73. SIGNATURE OF BUREAU		74. SIGNATURE OF DIVISION		75. SIGNATURE OF SECTION		76. SIGNATURE OF BRANCH		77. SIGNATURE OF OFFICE	
74. SIGNATURE OF BUREAU		75. SIGNATURE OF DIVISION		76. SIGNATURE OF SECTION		77. SIGNATURE OF BRANCH		78. SIGNATURE OF OFFICE	
75. SIGNATURE OF BUREAU		76. SIGNATURE OF DIVISION		77. SIGNATURE OF SECTION		78. SIGNATURE OF BRANCH		79. SIGNATURE OF OFFICE	
76. SIGNATURE OF BUREAU		77. SIGNATURE OF DIVISION		78. SIGNATURE OF SECTION		79. SIGNATURE OF BRANCH		80. SIGNATURE OF OFFICE	
77. SIGNATURE OF BUREAU		78. SIGNATURE OF DIVISION		79. SIGNATURE OF SECTION		80. SIGNATURE OF BRANCH		81. SIGNATURE OF OFFICE	
78. SIGNATURE OF BUREAU		79. SIGNATURE OF DIVISION		80. SIGNATURE OF SECTION		81. SIGNATURE OF BRANCH		82. SIGNATURE OF OFFICE	
79. SIGNATURE OF BUREAU		80. SIGNATURE OF DIVISION		81. SIGNATURE OF SECTION		82. SIGNATURE OF BRANCH		83. SIGNATURE OF OFFICE	
80. SIGNATURE OF BUREAU		81. SIGNATURE OF DIVISION		82. SIGNATURE OF SECTION		83. SIGNATURE OF BRANCH		84. SIGNATURE OF OFFICE	
81. SIGNATURE OF BUREAU		82. SIGNATURE OF DIVISION		83. SIGNATURE OF SECTION		84. SIGNATURE OF BRANCH		85. SIGNATURE OF OFFICE	
82. SIGNATURE OF BUREAU		83. SIGNATURE OF DIVISION		84. SIGNATURE OF SECTION		85. SIGNATURE OF BRANCH		86. SIGNATURE OF OFFICE	
83. SIGNATURE OF BUREAU		84. SIGNATURE OF DIVISION		85. SIGNATURE OF SECTION		86. SIGNATURE OF BRANCH		87. SIGNATURE OF OFFICE	
84. SIGNATURE OF BUREAU		85. SIGNATURE OF DIVISION		86. SIGNATURE OF SECTION		87. SIGNATURE OF BRANCH		88. SIGNATURE OF OFFICE	
85. SIGNATURE OF BUREAU		86. SIGNATURE OF DIVISION		87. SIGNATURE OF SECTION		88. SIGNATURE OF BRANCH		89. SIGNATURE OF OFFICE	
86. SIGNATURE OF BUREAU		87. SIGNATURE OF DIVISION		88. SIGNATURE OF SECTION		89. SIGNATURE OF BRANCH		90. SIGNATURE OF OFFICE	
87. SIGNATURE OF BUREAU		88. SIGNATURE OF DIVISION		89. SIGNATURE OF SECTION		90. SIGNATURE OF BRANCH		91. SIGNATURE OF OFFICE	
88. SIGNATURE OF BUREAU		89. SIGNATURE OF DIVISION		90. SIGNATURE OF SECTION		91. SIGNATURE OF BRANCH		92. SIGNATURE OF OFFICE	
89. SIGNATURE OF BUREAU		90. SIGNATURE OF DIVISION		91. SIGNATURE OF SECTION		92. SIGNATURE OF BRANCH		93. SIGNATURE OF OFFICE	
90. SIGNATURE OF BUREAU		91. SIGNATURE OF DIVISION		92. SIGNATURE OF SECTION		93. SIGNATURE OF BRANCH		94. SIGNATURE OF OFFICE	
91. SIGNATURE OF BUREAU		92. SIGNATURE OF DIVISION		93. SIGNATURE OF SECTION		94. SIGNATURE OF BRANCH		95. SIGNATURE OF OFFICE	
92. SIGNATURE OF BUREAU		93. SIGNATURE OF DIVISION		94. SIGNATURE OF SECTION		95. SIGNATURE OF BRANCH		96. SIGNATURE OF OFFICE	
93. SIGNATURE OF BUREAU		94. SIGNATURE OF DIVISION		95. SIGNATURE OF SECTION		96. SIGNATURE OF BRANCH		97. SIGNATURE OF OFFICE	
94. SIGNATURE OF BUREAU		95. SIGNATURE OF DIVISION		96. SIGNATURE OF SECTION		97. SIGNATURE OF BRANCH		98. SIGNATURE OF OFFICE	
95. SIGNATURE OF BUREAU		96. SIGNATURE OF DIVISION		97. SIGNATURE OF SECTION		98. SIGNATURE OF BRANCH		99. SIGNATURE OF OFFICE	
96. SIGNATURE OF BUREAU		97. SIGNATURE OF DIVISION		98. SIGNATURE OF SECTION		99. SIGNATURE OF BRANCH		100. SIGNATURE OF OFFICE	

RECEIVED  
JAN 10 1904  
BALTIMORE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00594

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Dorchester</span> <span style="float: right;">0609</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Dorchester</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Hurlock - Rural</span>		c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">Life</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <span style="font-size: 1.2em;">Hurlock - Rural</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Near Harrison Ferry</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">Near Harrison Ferry</span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="font-size: 1.2em;">David</span> Middle <span style="font-size: 1.2em;">Franklin</span> Last <span style="font-size: 1.2em;">Corkran</span>				<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">January</span> Day <span style="font-size: 1.2em;">10</span> Year <span style="font-size: 1.2em;">1960</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">Sept. 7, 1959</span>		<b>9. AGE</b> (in years last birthday) yrs. <span style="font-size: 1.2em;">4</span>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Infant</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">None</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Easton, Maryland</span>			
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Grover Corkran, Jr.</span>				<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Norma Donovan</span>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">None</span>		<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mrs. Grover Corkran, Jr., Hurlock, Md., RFD</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Toxemia</span> <span style="font-size: 1.5em;">527.2</span> DUE TO <span style="font-size: 1.2em;">Acute respiratory infection</span> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 day</span>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Hour <span style="font-size: 1.2em;">19</span> a. m. <span style="font-size: 1.2em;">p. m.</span>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">John Mace Jr.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">John Mace Jr.</span>				<b>DATE SIGNED</b> <span style="font-size: 1.2em;">1/10/60</span>			
<b>22a. REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Jan. 11, 1960</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Zion Cemetery</span>			
<b>22d. LOCATION (City, town, or county)</b> (State) <span style="font-size: 1.2em;">Near Williamsburg, Md.</span>				<b>24a. REC'D BY REGISTRAR</b> DATE <span style="font-size: 1.2em;">JAN 12 '60</span>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <span style="font-size: 1.2em;">J.J. Frampton and Son, Federalsburg, Maryland</span>				<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Kiana</span>			

2080258XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

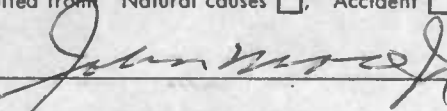
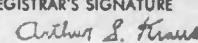
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00595

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>0610</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock - rural</b>			c. LENGTH OF STAY IN 1b <b>3 years</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Hurlock - Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Milligantown</b>				d. STREET ADDRESS <b>/ Milligantown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Hall</b> Kimball Last <b>Cornish</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>19 60</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1, 1908</b>		
9. AGE (In years last birthday) <b>51 yrs.</b>		IF UNDER 1 YEAR Months <b>51</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Thomson, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simeon Hamilton</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Lou Ruff</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>253-42-1287</b>		17. INFORMANT <b>Sarah Hobbs, Hurlock, Maryland, R.F.D.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> DUE TO <b>981X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gun shot wound chest</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Few Min.</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Was shot by pistol.</b>						
20c. TIME OF INJURY Month, Day, Year Hour <b>1 AM</b> a. m. <b>1-25-60</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hurlock Dor. Md.</b>		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE 				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 30, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 5 '60</b>		24b. REGISTRAR'S SIGNATURE 		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00596

Reg. Dist. No.

0592

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Maryland.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>100 Locust, St.</u>			d. STREET ADDRESS <u>101 Academy, St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Elmer C. Dayton</u>			4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/17/1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William Dayton</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Horseman</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <u>No</u>		
16. SOCIAL SECURITY NO. <u>Unknown</u>			17. INFORMANT <u>Randall Dayton, 101 Academy St., Cambridge, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/4/60</u>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/5/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>East New Market Cem</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in accordance with 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 100

BROD

100

100

100

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. Includes checkboxes for various conditions and a section for the medical examiner's signature and seal.

Vertical text on the right margin, likely a filing or processing stamp, including the words "RECEIVED" and "FILED".

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00597

6611

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellington</u>		c. LENGTH OF STAY IN 1b <u>all life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellington</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Corbett</u> Middle <u>Jeffrey</u> Last <u>Ellington</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/21/1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Water</u>	11. BIRTHPLACE (State or foreign country) <u>Ellington, Md</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>		13. FATHER'S NAME <u>Jesse Elliott</u>	
14. MOTHER'S MAIDEN NAME <u>Ira Moore</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>—</u> (c) <u>—</u> DUE TO cause lost. (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> o. m. <u>—</u> p. m. <u>—</u>	Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>
20f. (City or town) <u>—</u>		(County) <u>—</u> (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>John Mace Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ellington</u>	22d. LOCATION (City, town, or county) (State) <u>Ellington Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraw</u>		ADDRESS <u>South S. Hollingsby East New Market, Md</u>	
24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0594 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00599**

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>				d. STREET ADDRESS <b>Edgewood Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Eddie</b> First <b>Fussell</b> Last				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>		9. AGE (In years last birthday) <b>About 55</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ant labor</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>Cambridge Police Dept. Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<b>1/22/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1/23/1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board University Hosp.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. St. Clair Jr.</i>				24a. REC'D BY REGISTRAR DATE <b>JAN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
Cambridge, Md.							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00600

0612

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>203 Choptank Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Armetta</b> Last <b>Geoghegan</b>		4. DATE OF DEATH Month <b>January</b> Day <b>7</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-21-79</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Brannock</b>		14. MOTHER'S MAIDEN NAME <b>Susan Eliza Maguire</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Cardiovascular Disease</b> <b>422.1</b> DUE TO <b>General Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>December 29 1959</b> , to <b>January 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>January 7</b> , 19 <b>60</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Ettore DeFilippis</b> M.D. <b>E.S.S. Hospital, Cambridge, Md.</b>		1-7-60	
PHYSICIAN'S NAME (Type) <b>Dr. Ettore DeFilippis</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/9/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DOR MEMO. PK</b>	22d. LOCATION (City, town, or county) (State) <b>CAMBRIDGE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte FUNERAL SERVICE</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kane</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0613 CERTIFICATE OF DEATH

Reg. Dist. No.

00601

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Q.A.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>3 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KATIE MAY GORDON</b> First Middle Last		4. DATE OF DEATH <b>Jan. 19 1960</b> Month Day Year	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/14/79</b>
9. AGE (In years lost birthday) yrs. <b>80</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Sidney Radcliff</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Clark</b> ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome, cerebral arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12, 1956</b> to <b>Jan 19, 1960</b> , that I last saw the deceased alive on <b>Jan 19, 1960</b> , and that death occurred at <b>1:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>1-19-60</b>			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b>		M.D. <b>E.S.S. Hospital, Cambridge, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 21-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Stonewall</b>		22d. LOCATION (City, town, or county) (State) <b>Stonewall Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Baker, Jr. Baltimore, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>JAN 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. P. P.</b>	



1944

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UNITED STATES OF AMERICA

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UNITED STATES OF AMERICA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0595 CERTIFICATE OF DEATH

Reg. Dist. No.

00602

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Maryland</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>401 Byrn St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland, Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Oliver</u> Middle <u>T.</u> Last <u>Gray</u>		4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/24/1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>1</u> Min. <u>0</u>	IF UNDER 24 HRS. Months <u>0</u> Days <u>5</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mailman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mailman</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Gray</u>		14. MOTHER'S MAIDEN NAME <u>Emily Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WN 1 Unknown</u>	
17. INFORMANT <u>Le Compte Funeral Service, Records.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis, marked</u> DUE TO (c) <u>Arteriosclerosis generalized</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>3-4 mins.</u> <u>unknown</u> <u>unknown</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, mild</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --	
20c. TIME OF INJURY Month, Day, Year Hour a. m. -- -- 19 p. m. -- --		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --		20f. (City or town) (County) (State) -- --	
21. I certify that I attended the deceased from <u>10-23-59</u> , 19 <u>59</u> , to <u>1-8-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-8-60</u> , 19 <u>60</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		ADDRESS (Street, city or town, state) <u>15 Locust Street, Cambridge, Md.</u>	
DATE SIGNED <u>1-6-60</u>			
PHYSICIAN'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/8/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '60</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	









0596

CERTIFICATE OF DEATH

00604

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md. R.F.D. #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland, Hospital.</u>		d. STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>H.</u> Last <u>Handley</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/18/1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Handley</u>		14. MOTHER'S MAIDEN NAME <u>Cohralia Seward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>212-14-4276</u>	
17. INFORMANT <u>Mrs. Charles Handley, R.F.D. #1 Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/30/60</u> , 19 <u>60</u> , to <u>1/30</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/30</u> , 19 <u>60</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.		DATE SIGNED <u>136 Race St.</u>	
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		<u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/2/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24. REC'D BY REGISTRAR <u>DATE FEB 8 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BM 2/57

1  
FOR STATE HEALTH DEPT.  
64461  
2708 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY <b>27yr. 9mo. 12das</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		e. STREET ADDRESS <b>R.D. 4</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>P.</b> Last <b>Hardin</b>		4. DATE OF DEATH Month <b>January</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-14-77</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Towers</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Payne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>Unkn.</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>RECORDS - Eastern Shore State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>420.1</b> (c), stating the underlying cause lost. (c) <b>420.1</b>				INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/12/60</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/15/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Landing Neck Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Talbot County, Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Conoll, Easton, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>APR 19 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00606**

**0597**

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>2 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Rosalie</b> Middle <b>B.</b> Last <b>Henry</b>		4. DATE OF DEATH Month <b>January</b> Day <b>29</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/10/1899</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J.E. Boston</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Phillips</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Percy Henry</b>		Address <b>East New Market, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		DATE SIGNED <b>1-30-60</b>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>1/31/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East New Market</b>	22d. LOCATION (City, town, or county) (State) <b>East New Market Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Halloway</b>		24a. REC'D BY REGISTRAR <b>FEB 5 '60</b> DATE	
ADDRESS <b>East New Market</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Halloway</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH—BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00607

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Dorchester</span> <span style="float: right; font-size: 1.5em;">0598</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Maryland</span> b. COUNTY <span style="font-size: 1.2em;">Dorchester</span>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Cambridge</span>			c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">25 yrs.</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">13 Cambridge</span>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">64 Douglas St.</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">1 64 Douglas St.</span>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <div style="display: flex; justify-content: space-around;"> <span>First <span style="font-size: 1.2em;">Samuel</span></span> <span>Middle</span> <span>Last <span style="font-size: 1.2em;">Irving</span></span> </div>				<b>4. DATE OF DEATH</b> <div style="display: flex; justify-content: space-around;"> <span>Month <span style="font-size: 1.2em;">January</span></span> <span>Day <span style="font-size: 1.2em;">22</span></span> <span>Year <span style="font-size: 1.2em;">1960</span></span> </div>							
5. SEX <span style="font-size: 1.2em;">Male</span>		6. COLOR OR RACE <span style="font-size: 1.2em;">Negro</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">7/9/1898</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">61</span> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>			10b. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">General</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">South Carolina</span>			12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">Butler Irving</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Emma Irving</span>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">217-10-8870</span>		17. INFORMANT Address <span style="font-size: 1.2em;">Mrs. Maggie Irving 64 Douglas St.</span>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="border: 1px solid black; padding: 5px;">           PART I. DEATH WAS CAUSED BY:            IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Coronary occlusion</span>  <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">420.1</span> <span>DUE TO</span> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;">             Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           </div> <div style="width: 30%;">             (b) _____              DUE TO _____              (c) _____           </div> </div> </div>									INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Instant</span>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.      Month, Day, Year      19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)      (County)      (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <span style="font-size: 1.5em; font-family: cursive;">John Mace Jr.</span> EXAMINER'S NAME (Type) <span style="font-size: 1.2em;">John Mace Jr. MD.</span>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <span style="font-size: 1.2em;">1/25/60</span>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			22b. DATE THEREOF <span style="font-size: 1.2em;">1/26/60</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Bethel Cemetery</span>			22d. LOCATION (City, town, or county)      (State) <span style="font-size: 1.2em;">Cambridge, Dor. Md.</span>			
23. FUNERAL DIRECTOR'S SIGNATURE <span style="font-size: 1.2em;">Herbert StClair</span>					ADDRESS <span style="font-size: 1.2em;">Cambridge, Md.</span>			24a. REC'D BY REGISTRAR DATE <span style="font-size: 1.2em;">JAN 28 '60</span>		24b. REGISTRAR'S SIGNATURE <span style="font-size: 1.2em; font-family: cursive;">Arthur E. Evans</span>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH 1932		PLACE OF DEATH HOME	
AGE 65		SEX MALE	
RACE WHITE		OCCUPATION RETIRED	
EDUCATION HIGH SCHOOL		MARRIAGE MARRIED	
RELIGION METHODIST		PREVIOUS ILLNESS NONE	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL	
SIGNATURE OF EXAMINER J. H. SMITH		DATE JAN 10 1932	
LOCALITY BALTIMORE		COUNTY BALTIMORE	
STATE MARYLAND		FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE	

RECEIVED  
JAN 10 1932  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00608

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <span style="float: right;">0599</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9 Ceader St.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland.</u> d. STREET ADDRESS <u>9 Ceader St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Missouri</u> Middle <u>Lankford</u> Last <u>Lankford</u> <b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>9</u> Year <u>1960</u>				<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>January 2 1873</u> <b>9. AGE</b> (In years last birthday) <u>87</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Housewife</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Asora Hurley</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Sallie Horseman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Mrs. Walter Daisey, Salisbury, Maryland.</u> Address <u>  </u>				<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> <u>331X</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> (b) <u>  </u> (c) <u>  </u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>John Mace Jr.</u> <b>EXAMINER'S NAME</b> (Type) <u>Dr. John Mace Jr.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>1/10/60</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>1/12/60</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Dorchester Mem. Park</u>			
<b>22d. LOCATION</b> (City, town, or county) (State) <u>Cambridge, Maryland.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Le Compte Funeral Service, Cambridge, Md.</u> ADDRESS <u>  </u>					
<b>24c. REC'D BY REGISTRAR</b> <u>JAN 14 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

000000

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner's signature. The form is oriented vertically and contains various checkboxes and lines for text entry.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00699

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>125 Race St.</b>		d. STREET ADDRESS <b>125 Race St.</b>	
3. NAME OF DECEASED (Type or print) <b>Clara E. Lewis</b>		4. DATE OF DEATH Month <b>Jan</b> Day <b>22</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 1, 1893</b>
10a. USUAL OCCUPATION (Give kind of work done throughout working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Meekins Travers</b>		14. MOTHER'S MAIDEN NAME <b>U known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>U known</b>	17. INFORMANT <b>Mrs Roland Burton</b> Address <b>Cambridge Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/21</b> , 19 <b>60</b> , to <b>1/22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1/22</b> , 19 <b>60</b> , and that death occurred at <b>11:25</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 Race St Cambridge, Md</b> DATE SIGNED <b>1/23/60</b>			
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov Cambridge, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Jan 24, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leconte Funeral Service</b>		24a. REC'D BY REGISTRAR <b>JAN 28 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. [Signature]</b>

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]	
AGE [Handwritten: 45]		DATE OF BIRTH [Handwritten: 10-15-1880]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		CITY OF DEATH [Handwritten: Baltimore, Md.]	
OCCUPATION [Handwritten: Clerk]		CAUSE OF DEATH [Handwritten: Heart Disease]	
DATE OF DEATH [Handwritten: 10-20-1920]		TIME OF DEATH [Handwritten: 10:00 AM]	
PLACE OF DEATH [Handwritten: Home]		NAME OF PHYSICIAN [Handwritten: Dr. J. H. Smith]	
NAME OF FUNERAL HOME [Handwritten: N/A]		NAME OF BURIAL PLACE [Handwritten: N/A]	
NAME OF NEXT OF KIN [Handwritten: N/A]		NAME OF WITNESS [Handwritten: N/A]	
NAME OF REGISTRAR [Handwritten: N/A]		NAME OF CLERK [Handwritten: N/A]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0615 CERTIFICATE OF DEATH

Reg. Dist. No.

00610

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>TALBOT</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> 20 40.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>		d. STREET ADDRESS <u>116 S. AURORA ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>L. FRANK LEWIS</u>		4. DATE OF DEATH Month Day Year <u>JAN. 21 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 23, 1905</u> 34 yrs.
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSE PAINTER</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK LEVIN LEWIS</u>		14. MOTHER'S MAIDEN NAME <u>SALLY BELL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC MYOCARDITIS</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE</u> , 1957, to <u>JAN. 21, 1960</u> , that I last saw the deceased alive on <u>JAN. 21, 1960</u> , and that death occurred at <u>5:47 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ettore DeFilippis</u> M.D.		ADDRESS (Street, city or town, state) <u>EASTERN SHORE STATE HOSP.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>ETTORE DEFILIPPIS</u>		<u>CAMBRIDGE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>JAN 23, 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellie R. Clark</u> ADDRESS <u>Easton Md</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kious</u>
DATE <u>JAN 25 1960</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00611

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>		c. LENGTH OF STAY IN 1b <u>8 Hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood, Maryland.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge, Maryland., Hospital.</u>			d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W.</u> Last <u>Linthicum</u>			4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/1930</u>		9. AGE (In years last birthday) <u>29</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Thomas Linthicum</u>			14. MOTHER'S MAIDEN NAME <u>Agnes Tyler</u>		
15. WAS DECEASED EVER IN U. S. ARMED SERVICES (If yes, give war or dates of service) <u>Yes</u> <u>WW-2 1951</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Le Compte Funeral Service, Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intercranial injury</u></p> <p><u>825x</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture base of skull</u></p> <p>DUE TO (c) _____</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>1 Hr.</u></p> <p><u>1 Hr.</u></p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pagenger in auto accident</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:30</u> <u>1/12/60</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Church Creek, Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>1/13/60</u>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1/14/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Trinity Church Yard.</u>		22d. LOCATION (City, town, or county) (State) <u>Church Creek, Maryla nd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kram</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
DEATH CERT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0001

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Date of Death: \_\_\_\_\_

8. Time of Death: \_\_\_\_\_

9. Place of Death: \_\_\_\_\_

10. Cause of Death: \_\_\_\_\_

11. Manner of Death: \_\_\_\_\_

12. Signature of Medical Examiner: \_\_\_\_\_

13. Title of Medical Examiner: \_\_\_\_\_

14. Date of Signature: \_\_\_\_\_

15. Signature of Coroner: \_\_\_\_\_

16. Title of Coroner: \_\_\_\_\_

17. Date of Signature: \_\_\_\_\_

18. Signature of Registrar: \_\_\_\_\_

19. Title of Registrar: \_\_\_\_\_

20. Date of Signature: \_\_\_\_\_



0616

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Andrews, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura</u> Middle <u>Hughes</u> Last <u>Moore</u>				4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/11/1883</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>		IF UNDER 24 HRS. Months <u>76</u> Days <u>76</u> Hours <u>76</u> Min. <u>76</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Andrews, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Levin Soloman Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mr. Gordy Moore, Andrews, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7</u> DAYS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROSIS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12/27</u> , 19 <u>59</u> , to <u>1/5</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>60</u> , and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.				ADDRESS (Street, city or town, state) <u>136 RACE ST. CAMBRIDGE MD.</u>			
PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV</u>				DATE SIGNED <u>1/8/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Church Yard.</u>	
22d. LOCATION (City, town, or county) (State) <u>Andrews, Maryland.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>				24a. REC'D BY REGISTRAR <u>JAN 11 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. DATE OF INTERMENT		15. TIME OF INTERMENT	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF CLERK		20. SIGNATURE OF REGISTRAR	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF CLERK		25. SIGNATURE OF REGISTRAR	
26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESSES		28. SIGNATURE OF PHYSICIAN		29. SIGNATURE OF CLERK		30. SIGNATURE OF REGISTRAR	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF WITNESSES		33. SIGNATURE OF PHYSICIAN		34. SIGNATURE OF CLERK		35. SIGNATURE OF REGISTRAR	
36. SIGNATURE OF DECEASED		37. SIGNATURE OF WITNESSES		38. SIGNATURE OF PHYSICIAN		39. SIGNATURE OF CLERK		40. SIGNATURE OF REGISTRAR	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF WITNESSES		43. SIGNATURE OF PHYSICIAN		44. SIGNATURE OF CLERK		45. SIGNATURE OF REGISTRAR	
46. SIGNATURE OF DECEASED		47. SIGNATURE OF WITNESSES		48. SIGNATURE OF PHYSICIAN		49. SIGNATURE OF CLERK		50. SIGNATURE OF REGISTRAR	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF WITNESSES		51. SIGNATURE OF PHYSICIAN		52. SIGNATURE OF CLERK		53. SIGNATURE OF REGISTRAR	
54. SIGNATURE OF DECEASED		55. SIGNATURE OF WITNESSES		56. SIGNATURE OF PHYSICIAN		57. SIGNATURE OF CLERK		58. SIGNATURE OF REGISTRAR	
59. SIGNATURE OF DECEASED		60. SIGNATURE OF WITNESSES		61. SIGNATURE OF PHYSICIAN		62. SIGNATURE OF CLERK		63. SIGNATURE OF REGISTRAR	
64. SIGNATURE OF DECEASED		65. SIGNATURE OF WITNESSES		66. SIGNATURE OF PHYSICIAN		67. SIGNATURE OF CLERK		68. SIGNATURE OF REGISTRAR	
69. SIGNATURE OF DECEASED		70. SIGNATURE OF WITNESSES		71. SIGNATURE OF PHYSICIAN		72. SIGNATURE OF CLERK		73. SIGNATURE OF REGISTRAR	
74. SIGNATURE OF DECEASED		75. SIGNATURE OF WITNESSES		76. SIGNATURE OF PHYSICIAN		77. SIGNATURE OF CLERK		78. SIGNATURE OF REGISTRAR	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF WITNESSES		81. SIGNATURE OF PHYSICIAN		82. SIGNATURE OF CLERK		83. SIGNATURE OF REGISTRAR	
84. SIGNATURE OF DECEASED		85. SIGNATURE OF WITNESSES		86. SIGNATURE OF PHYSICIAN		87. SIGNATURE OF CLERK		88. SIGNATURE OF REGISTRAR	
89. SIGNATURE OF DECEASED		90. SIGNATURE OF WITNESSES		91. SIGNATURE OF PHYSICIAN		92. SIGNATURE OF CLERK		93. SIGNATURE OF REGISTRAR	
94. SIGNATURE OF DECEASED		95. SIGNATURE OF WITNESSES		96. SIGNATURE OF PHYSICIAN		97. SIGNATURE OF CLERK		98. SIGNATURE OF REGISTRAR	
99. SIGNATURE OF DECEASED		100. SIGNATURE OF WITNESSES		101. SIGNATURE OF PHYSICIAN		102. SIGNATURE OF CLERK		103. SIGNATURE OF REGISTRAR	

104. SIGNATURE OF DECEASED

105. SIGNATURE OF WITNESSES

106. SIGNATURE OF PHYSICIAN

107. SIGNATURE OF CLERK

108. SIGNATURE OF REGISTRAR

## 0617 CERTIFICATE OF DEATH

Reg. Dist. No.

00613

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3yr. 5mo. 2das.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>MAY</b> Last <b>NORTH</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-19-85</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13. FATHER'S NAME <b>George North</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Hospital records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>August 20</b> , 19 <b>56</b> , to <b>Jan 22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 22</b> , 19 <b>60</b> , and that death occurred at <b>1:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>E.S.S. Hospital, Cambridge, Md. 1/22/60</b>							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D. <b>Kenneth R. Thomas</b>							
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 25, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>				24. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>			
ADDRESS <b>Cambridge, Md.</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

INDICATE ON EACH

1130

RECEIVED

RECEIVED

1130

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0618 CERTIFICATE OF DEATH

Reg. Dist. No.

00614

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Golden Hill, Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Etta</u> Middle <u>Tyler</u> Last <u>Phillips</u>		4. DATE OF DEATH Month <u>1</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/1872</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jabez Tyler</u>		14. MOTHER'S MAIDEN NAME <u>Emily Goottee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Le Compte Funeral Service, Cambridge, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease - Congestive Failure</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-16</u> , 19 <u>58</u> , to <u>1-31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>60</u> , and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Cambridge</u> DATE SIGNED <u>2-3-60</u>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		PHYSICIAN'S NAME (Type) <u>Cambridge</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE OF DEATH

NAME OF DECEASED JOHN B. SMITH		SEX Male	
AGE 45		DATE OF BIRTH 10/15/1905	
PLACE OF BIRTH New York City		RACE White	
OCCUPATION Clerk		MARITAL STATUS Married	
DATE OF DEATH 11/10/1950		TIME OF DEATH 10:30 AM	
PLACE OF DEATH Home		CAUSE OF DEATH Myocardial Infarction	
MEDICAL HISTORY Hypertension, Diabetes		PRESENT ILLNESS Chest pain, shortness of breath	
TREATMENT Aspirin, Nitroglycerin		POSTMORTEM No	
SIGNATURE OF PHYSICIAN Dr. J. K. Doe		SIGNATURE OF WITNESSES Mr. A. B. Smith, Mrs. C. D. Smith	
SIGNATURE OF REGISTRAR E. F. G.		OFFICIAL SEAL State of New York	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Albany, New York, and a copy of the same is to be sent to the local health officer of the place where the death occurred.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00615

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>49 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>				d. STREET ADDRESS <b>103 Glenburn Ave.,</b>											
3. NAME OF DECEASED (Type or print) First <b>Margaretha</b> Middle <b>Sticht</b> Last <b>Pink</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>											
5. SEX <b>Female</b> <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		8. DATE OF BIRTH <b>March 26, 1879</b>		9. AGE (In years last birthday) <b>80 yrs.</b>		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N.Y.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Carsten Sticht</b>						14. MOTHER'S MAIDEN NAME <b>Gesena Brede</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Miss Nina E. Pink, 103 Glenburn Ave., Cambridge, Md.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>434.1 Congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>										INTERVAL BETWEEN ONSET AND DEATH <b>3 hr 40min.</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>Jan. 15, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Levin R. Lerner</b>						ADDRESS <b>Cambridge, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00616

Reg. Dist. No.

0619

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester, Maryland</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b>		c. LENGTH OF STAY IN 1b <b>5YR.-10MO.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cambridge-Hoopersville, Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>E.S.S. Hospital</b>				d. STREET ADDRESS <b>NOWE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cloria</b> Middle <b>Riggins</b> Last <b>Riggins</b>				4. DATE OF DEATH Month <b>1</b> Day <b>9</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-18-80</b>		9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NOWE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James White</b>				14. MOTHER'S MAIDEN NAME <b>Clementine Lewis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>EASTERN SHORE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>465X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>12 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James M. ...</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Mount Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Laurel Mount Park</i>				ADDRESS <b>Cambridge Md</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '60</b>	
						24b. REGISTRAR'S SIGNATURE <i>Arthur L. ...</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**THE UNIVERSITY OF CHICAGO**

0603

## Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If no information, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, Maryland</b>		c. LENGTH OF STAY IN 1b <b>6 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head, Maryland</b>		d. STREET ADDRESS <b>None</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge, Maryland Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Marea Bayliss Robinson</b>		First Middle Last		4. DATE OF DEATH Month Day Year <b>1 3 19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/17/1892</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Bayliss</b>		14. MOTHER'S MAIDEN NAME <b>Georianna Bayliss</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-05-8027</b>		17. INFORMANT <b>Le Compte Funeral Service, Records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>586X</b> DUE TO <b>ARTERIAL DYSREGULATION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIAL DYSREGULATION</b> DUE TO (c) <b>ACUTE RUPTURED GALLBLADDER 4 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 Hours</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/10/1949</b> to <b>1/3/1960</b> , that I last saw the deceased alive on <b>1/3/1960</b> , and that death occurred at <b>8 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 LOCUST ST CAMBRIDGE Md.</b> DATE SIGNED <b>1/4/60</b>							
ACTUAL SIGNATURE <b>W. H. Hanks</b>		M.D. <b>104 LOCUST ST</b>					
PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/60.</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Robinson Family Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bishops Head, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Le Compte Funeral Service, Cambridge, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 9/5S







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G255 2-8-60 et

Reg. Dist. No.

00618

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>DORCHESTER</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CAMBRIDGE</b>			c. LENGTH OF STAY IN 1b		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EASTERN SHORE STATE HOSPITAL</b>			e. STREET ADDRESS <b>R.F.D.#1 (Union Rd)</b>		
3. NAME OF DECEASED (Type or print) <b>FRANK J. TOADVINE</b>			4. DATE OF DEATH <b>JANUARY 30 1960</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-15-98</b>		9. AGE (In years last birthday) <b>61 1/2</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM HAND</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Wico. Co.</b>
13. FATHER'S NAME <b>THEODORE F. TOADVINE</b>			14. MOTHER'S MAIDEN NAME <b>ANNIE W. HALL</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN No</b>			16. SOCIAL SECURITY NO. <b>NONE</b>		
17. INFORMANT <b>Mr. Merrill W. Toadvine (Brother)</b>			18. <b>EASTERN SHORE STATE HOSPITAL RECORDS</b>		
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT</b>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace Jr.</b>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>JOHN MACE JR.</b>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 3, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Salisbury, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>			ADDRESS <b>SALISBURY MARYLAND</b>		
24a. REC'D BY REGISTRAR <b>DATE FEB 2 '60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>		



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00619

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Maryland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>13 Cambridge, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge, Maryland Hospital</u>				d. STREET ADDRESS <u>119 Choptank Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>G.</u> Last <u>Vickers</u>				4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/19/1887</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Taylors Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Greenbury Vickers</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Geoghegan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WN-1</u>		17. INFORMANT <u>Mrs. Edward Vickers, 119 Choptank Ave.</u>		Address <u>Cambridge, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma lung</u> DUE TO (b) <u>with metastasis</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10</u> , 19 <u>60</u> , to <u>1/9</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/9</u> , 19 <u>60</u> ; and that death occurred at <u>5 p. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. H. Anks</u>				DATE SIGNED <u>1/9/60</u>			
PHYSICIAN'S NAME (Type) <u>W. H. H. Anks</u>				ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00620

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Dorchester Co.</u> <span style="float: right;">0621</span> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna, Maryland, R.F.D. # 1</u> d. STREET ADDRESS <u>None</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna, Maryland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>				f. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1960</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Winfield</u> Middle <u>Scott</u> Last <u>Willey</u>				<b>4. DATE OF DEATH</b> Month <u>1</u> Day <u>28</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>9/23/1890</u>		9. AGE (in years last birthday) <u>69</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel J. Willey</u>		14. MOTHER'S MAIDEN NAME <u>Bertie Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Scott Willey Jr., Vienna, Md. R.F.D. # 1</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Arteriosclerosis generalized</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>---</u> a. m. <u>---</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>			
20f. (City or town) <u>---</u>		(County) <u>---</u>		(State) <u>---</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>29th Jan. '60</u>			
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M. D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					
22b. DATE THEREOF <u>1/30/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Mem. Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 4 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		24c. REGISTRAR'S SIGNATURE <u>---</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF DEATH [REDACTED]		5. TIME OF DEATH [REDACTED]		6. PLACE OF DEATH [REDACTED]	
7. OCCUPATION [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. SIGNATURE OF EXAMINER [REDACTED]		11. SIGNATURE OF WITNESS [REDACTED]		12. SIGNATURE OF CORONER [REDACTED]	
13. SIGNATURE OF JURY [REDACTED]		14. SIGNATURE OF JURY [REDACTED]		15. SIGNATURE OF JURY [REDACTED]	
16. SIGNATURE OF JURY [REDACTED]		17. SIGNATURE OF JURY [REDACTED]		18. SIGNATURE OF JURY [REDACTED]	
19. SIGNATURE OF JURY [REDACTED]		20. SIGNATURE OF JURY [REDACTED]		21. SIGNATURE OF JURY [REDACTED]	
22. SIGNATURE OF JURY [REDACTED]		23. SIGNATURE OF JURY [REDACTED]		24. SIGNATURE OF JURY [REDACTED]	
25. SIGNATURE OF JURY [REDACTED]		26. SIGNATURE OF JURY [REDACTED]		27. SIGNATURE OF JURY [REDACTED]	
28. SIGNATURE OF JURY [REDACTED]		29. SIGNATURE OF JURY [REDACTED]		30. SIGNATURE OF JURY [REDACTED]	
31. SIGNATURE OF JURY [REDACTED]		32. SIGNATURE OF JURY [REDACTED]		33. SIGNATURE OF JURY [REDACTED]	
34. SIGNATURE OF JURY [REDACTED]		35. SIGNATURE OF JURY [REDACTED]		36. SIGNATURE OF JURY [REDACTED]	
37. SIGNATURE OF JURY [REDACTED]		38. SIGNATURE OF JURY [REDACTED]		39. SIGNATURE OF JURY [REDACTED]	
40. SIGNATURE OF JURY [REDACTED]		41. SIGNATURE OF JURY [REDACTED]		42. SIGNATURE OF JURY [REDACTED]	
43. SIGNATURE OF JURY [REDACTED]		44. SIGNATURE OF JURY [REDACTED]		45. SIGNATURE OF JURY [REDACTED]	
46. SIGNATURE OF JURY [REDACTED]		47. SIGNATURE OF JURY [REDACTED]		48. SIGNATURE OF JURY [REDACTED]	
49. SIGNATURE OF JURY [REDACTED]		50. SIGNATURE OF JURY [REDACTED]		51. SIGNATURE OF JURY [REDACTED]	
52. SIGNATURE OF JURY [REDACTED]		53. SIGNATURE OF JURY [REDACTED]		54. SIGNATURE OF JURY [REDACTED]	
55. SIGNATURE OF JURY [REDACTED]		56. SIGNATURE OF JURY [REDACTED]		57. SIGNATURE OF JURY [REDACTED]	
58. SIGNATURE OF JURY [REDACTED]		59. SIGNATURE OF JURY [REDACTED]		60. SIGNATURE OF JURY [REDACTED]	
61. SIGNATURE OF JURY [REDACTED]		62. SIGNATURE OF JURY [REDACTED]		63. SIGNATURE OF JURY [REDACTED]	
64. SIGNATURE OF JURY [REDACTED]		65. SIGNATURE OF JURY [REDACTED]		66. SIGNATURE OF JURY [REDACTED]	
67. SIGNATURE OF JURY [REDACTED]		68. SIGNATURE OF JURY [REDACTED]		69. SIGNATURE OF JURY [REDACTED]	
70. SIGNATURE OF JURY [REDACTED]		71. SIGNATURE OF JURY [REDACTED]		72. SIGNATURE OF JURY [REDACTED]	
73. SIGNATURE OF JURY [REDACTED]		74. SIGNATURE OF JURY [REDACTED]		75. SIGNATURE OF JURY [REDACTED]	
76. SIGNATURE OF JURY [REDACTED]		77. SIGNATURE OF JURY [REDACTED]		78. SIGNATURE OF JURY [REDACTED]	
79. SIGNATURE OF JURY [REDACTED]		80. SIGNATURE OF JURY [REDACTED]		81. SIGNATURE OF JURY [REDACTED]	
82. SIGNATURE OF JURY [REDACTED]		83. SIGNATURE OF JURY [REDACTED]		84. SIGNATURE OF JURY [REDACTED]	
85. SIGNATURE OF JURY [REDACTED]		86. SIGNATURE OF JURY [REDACTED]		87. SIGNATURE OF JURY [REDACTED]	
88. SIGNATURE OF JURY [REDACTED]		89. SIGNATURE OF JURY [REDACTED]		90. SIGNATURE OF JURY [REDACTED]	
91. SIGNATURE OF JURY [REDACTED]		92. SIGNATURE OF JURY [REDACTED]		93. SIGNATURE OF JURY [REDACTED]	
94. SIGNATURE OF JURY [REDACTED]		95. SIGNATURE OF JURY [REDACTED]		96. SIGNATURE OF JURY [REDACTED]	
97. SIGNATURE OF JURY [REDACTED]		98. SIGNATURE OF JURY [REDACTED]		99. SIGNATURE OF JURY [REDACTED]	
100. SIGNATURE OF JURY [REDACTED]		101. SIGNATURE OF JURY [REDACTED]		102. SIGNATURE OF JURY [REDACTED]	



DATE FEB 4 '61

